

SERFF Tracking Number: GRWE-127174695 State: Arkansas
 Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 48818
 Company Tracking Number: PPVULSA-CSO
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
 Product Name: Flexible Premium Variable UL
 Project Name/Number: Flexible Premium Variable UL/Flexible Premium Variable UL

Filing at a Glance

Company: Great-West Life & Annuity Insurance Company

Product Name: Flexible Premium Variable UL SERFF Tr Num: GRWE-127174695 State: Arkansas

TOI: L06I Individual Life - Variable SERFF Status: Closed-Approved- State Tr Num: 48818
 Closed

Sub-TOI: L06I.002 Single Life - Flexible Co Tr Num: PPVULSA-CSO State Status: Approved-Closed
 Premium

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Tanya Gonzales, Derek Smith Disposition Date: 06/07/2011

Date Submitted: 05/18/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Flexible Premium Variable UL

Status of Filing in Domicile: Not Filed

Project Number: Flexible Premium Variable UL

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Exempt in state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/07/2011

State Status Changed: 06/07/2011

Deemer Date:

Created By: Derek Smith

Submitted By: Derek Smith

Corresponding Filing Tracking Number:

Filing Description:

Individual Life Submission

Individual Flexible Premium Universal Life Policy,

Deletion of Page 1, Form PPVUL-CSO SF (Death Benefit Option 3)

Revised page 12, Form PPVULrev

Revised page 18, Form PPVULrev-CSO

Individual Flexible Premium Universal Life Application, Form PPVULappsar2

Fixed Account Endorsement, J379r2

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Company and Contact

Filing Contact Information

Tanya Gonzales, Associate Manager, tanya.gonzales@gwl.com
 Contracts
 8515 E. Orchard Rd. 8T2 800-537-2033 [Phone] 75829 [Ext]
 Greenwood Village, CO 80111 303-737-5444 [FAX]

Filing Company Information

Great-West Life & Annuity Insurance Company CoCode: 68322 State of Domicile: Colorado
 8515 East Orchard Road Group Code: 769 Company Type:
 Greenwood Village, CO 80111 Group Name: State ID Number:
 (303) 737-3992 ext. [Phone] FEIN Number: 84-0467907

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: (1 policy pages x \$50.00) + (1 application x \$50.00) + (1 endorsement x \$50.00)=\$150.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Great-West Life & Annuity Insurance Company	\$150.00	05/18/2011	47738807

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/07/2011	06/07/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	05/23/2011	05/23/2011	Tanya Gonzales	06/03/2011	06/03/2011

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Disposition

Disposition Date: 06/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Actuarial Memorandum		No
Form	Flexible Premium Variable UL Page 12		Yes
Form	Flexible Premium Variable UL Page 18		Yes
Form	Flexible Premium Variable UL Application		Yes
Form	Fixed Account Endorsement		Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/23/2011
Submitted Date	05/23/2011
Respond By Date	06/23/2011

Dear Tanya Gonzales,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment: The revised forms will need to have Rev.(with eff. date) printed after the form number.

Please feel free to contact me if you have questions.

Sincerely,
Linda Bird

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/03/2011
Submitted Date 06/03/2011

Dear Linda Bird,

Comments:

Thank you for your review of this filing. We appreciate your time and consideration.

Response 1

Comments: We respectfully request that this objection be reconsidered. These pages, as required, have a distinctive form number from what was previously approved which designates the change. If, we changed these pages again, we would change the form numbers to PPVULrev1 or PPVULrev2 for example. We have never been aware of the requirement mandating an effective date to be inserted next to the form number. If this is a new requirement please provide us with the citation. To make such a change would be inconsistent with our nomenclature causing additional Systems work.

Related Objection 1

Comment:

The revised forms will need to have Rev.(with eff. date) printed after the form number.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any additional questions or if you would further like to discuss this issue, please contact me at (303) 737-5829.

We look forward to your approval.

Sincerely,

Tanya Gonzales

Manager, Individual Markets

(303) 737-5829

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Sincerely,
Derek Smith, Tanya Gonzales

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Form Schedule

Lead Form Number: PPVULrev

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	PPVULrev	Policy/Cont Flexible Premium ract/Fratern Variable UL Page 12 al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	PPVULrev pg 12.pdf
	PPVULrev- CSO	Policy/Cont Flexible Premium ract/Fratern Variable UL Page 18 al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	PPVULrev- CSO pg 18.pdf
	PPVULapp sar2	Application/ Flexible Premium Enrollment Variable UL Form Application	Initial		0.000	PPVULappsar 2.pdf
	J379r2	Policy/Cont Fixed Account ract/Fratern Endorsement al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	J379r2 Fixed Account Endorsement. pdf

Death Benefit Provisions

DEATH BENEFIT PROVISION

The Death Benefit option for this policy as of the Issue Date is shown on Page 1. The Death Benefit is determined by the option in effect at the Insured's date of death.

Option 1: Level Death

The Death Benefit will be the face amount shown on Page 1, less any partial withdrawals, less any outstanding loans and loan interest accrued.

In some cases, growth of the Policy Value Account may require that the Company adjust the Death Benefit in order to comply with Internal Revenue Code regulations. In such an instance, the Death Benefit will be the Policy Value Account times the applicable factor shown in Table A, Death Benefit Factors, less any partial withdrawals, less any outstanding loans and loan interest accrued. The greater of this number or the face amount shown on Page 1 will be the Death Benefit.

Option 2: Coverage Plus

The Death Benefit will be the face amount shown on Page 1, plus the Policy Value Account on the date of the Insured's death, less any outstanding loans and loan interest accrued.

In some cases, growth of the Policy Value Account may require that the Company adjust the Death Benefit in order to comply with Internal Revenue Code regulations. In such an instance, the Death Benefit will be the Policy Value Account times the applicable factor shown in Table A, Death Benefit Factors, less any outstanding loans and loan interest accrued. The greater of this number or the face amount shown on Page 1, plus the Policy Value Account will be the Death Benefit.

CHANGE OF DEATH BENEFIT OPTION

After the first policy year, but not more than once each policy year, the Owner may change the Death Benefit option by Request. Any change will be effective on the first day of the policy month following the date the Company approves the Request. A maximum fee of \$100 will be deducted from the Policy Value Account for each change.

A change in the Death Benefit option is subject to the following conditions:

- If the change is from Option 1 to Option 2, the amount payable upon the death of the Insured will remain the same and the new face amount, at the time of the change, will equal the prior face amount less the Policy Value Account. Evidence of Insurability may be required.
- If the change is from Option 2 to Option 1, the amount payable upon the death of the Insured will remain the same and the new face amount, at the time of the change, will equal the prior face amount plus the Policy Value Account.

Policy Values, Loan and Nonforfeiture Provisions (continued)

PARTIAL WITHDRAWAL PROVISION

The Owner may make a partial withdrawal from the Policy Value Account at any time while the policy is in force. The minimum amount per withdrawal is \$500. The maximum amount that may be withdrawn is the amount that would result in a minimum \$1,000 Surrender Benefit remaining in the policy after the withdrawal.

There is no administrative fee charged for the first partial withdrawal in any policy year. However, a maximum administrative fee of \$25 will be deducted from the Policy Value Account for each additional partial withdrawal made in the same policy year.

The partial withdrawal will generally be effective on the Transaction Date. The Policy Value Account will be reduced by the withdrawal amount, which will be taken first on a pro rata basis from those Investment Divisions that contain assets immediately available to the Company and then from all other Investment Divisions subject to the Postponement provision.

If the policy is in force under Option 1, Level Death Benefit, then the Death Benefit also will be reduced by the amount of each withdrawal.

Withdrawals may not be repaid into the Policy Value Account. Any payments received will be subject to the Additional Premium Payments Provision.

POSTPONEMENT

If the Company receives a Request for surrender, partial withdrawal, or a loan, the Company may generally postpone any payment for up to 7 days.

To the extent permitted under applicable law, the Company will also generally defer the determination or payment of amounts payable under the policy whenever and for so long as it is impractical for the Company to determine the value of the assets of the Series Account including, without limitation, when the NYSE is closed for trading or when the SEC has determined that a state of emergency exists; or, as to illiquid investments, to effect the liquidation of such assets without penalty.

In addition, to the extent permitted under applicable law, notwithstanding any other provision in the policy to the contrary, for Investment Divisions that invest in Underlying Funds or other investment assets that are not valued or redeemable on a daily basis, the Company may defer, in whole or in part, the valuation of assets, the allocation of Premium, the processing of loan repayments, and the processing, determination and payment of any surrender, partial withdrawal, loan, Death Benefit Proceeds in excess of the face amount, or Transfer, until such assets may be acquired, valued, redeemed or otherwise liquidated, as applicable, in accordance with the specified terms and conditions of the applicable issuer, without penalty. If the Company defers, in whole or in part, the allocation of premium or loan repayments or any Transfer, amounts to be allocated to or transferred to or from one or more such Divisions may first be allocated to the Money Market Investment Division and will remain there until the Sub-Account Value may be invested in the applicable Divisions in accordance with the requirements of the applicable Underlying Funds or other investments.

During the postponement period, the Sub-Account Value may continue to be subject to the investment experience (gains or losses) of the Underlying Fund(s) and all applicable charges.

HOW VALUES ARE COMPUTED

All calculations are based on the Commissioners 2001 Standard Ordinary Smoker-Distinct and Sex-Distinct Mortality Table, age nearest birthday, at an interest rate of 4% per year. These computations assume that Death Benefits are to be paid at the end of the policy year in which death occurs. Any net single Premium will be computed on the basis of the Insured's Attained Age and Premium class.

A detailed statement of the method of computing the values of this policy has been filed with the Insurance Department of the state in which this policy is delivered. All policy values equal or exceed those required by the law of that state or jurisdiction.

PAYMENT OPTION

Subject to the Postponement provision, all amounts payable under the policy, including, but not limited to, Death Benefit Proceeds and any proceeds from any surrender, partial withdrawal or policy loan will be paid in a lump sum unless the Owner elects by Request to have all or a portion of such amounts paid under a different payment option that the Company may be offering from time to time.

Flexible Premium Variable Universal Life Insurance Application

Owner:

Name

Attention

Business Address

City State Zip Code

Owner's SS# or Tax ID #

Type of Business

Daytime Telephone Number

Evening Telephone Number

Insured:

Insured's Name

Date of Birth

Social Security #

Home Address

City State Zip Code

Business Address

City State Zip Code

Daytime Telephone Number

Evening Telephone Number

See attached Schedule of Insureds

Owner is: *(Please choose one of the following)*

- a. The Employer
- b. A Trust created by the Employer
- c. A Trust created by the Insured
- d. The Insured
- e. Other _____

Policy Information:

Life Insurance or Premium Applied for:

Total Face Amount: _____

Premium Amount: _____

Send Premium Notices to:

Name _____

Address _____

Death Benefit Option:

Please choose one of the following:

Option 1: Level Death Benefit

Option 2: Coverage Plus

Beneficiary(ies):

Please choose one of the following:

Employer Trust created by the Employer Trust created by the Insured

If the employer is the beneficiary, the employer certifies, represents and warrants that:

- a. The employer has a lawful and substantial economic interest in the life, health and safety of each proposed insured;
- b. The services of each such proposed insured are such that the employer expects to realize either:
 - A substantial monetary gain through the continued life of the proposed insured; or
 - A substantial monetary loss in the event of the proposed insured's death.
- c. Per the requirements set forth in I.R.C.§101(j), the insured:
 - had "compensation" in excess of the IRC § 414(q) limitation, as adjusted annually for inflation; or
 - is among the highest paid 35% of all employees, determined in accordance with the rules of IRC § 105(h); or
 - is an owner of 5% or more of the employer at any time during the year (or was in the preceding year); or
 - is among the top 5 highest paid officers of the company

Additionally, in order to comply with IRC§101(j), employers must obtain positive written consent from employees that the employer may insure their life. This consent must disclose that the corporation will reside as beneficiary of the policy death benefit and the maximum amount of insurance that may be issued on their life. This information must be obtained PRIOR to the issue of any policy. Failure to do so may result in adverse tax consequences.

Please sign below stating you have read and understand the above conditions.

Employer Name (Please Print)

Title

Employer Signature

Date

Citizenship Status:

Is each individual named on this application a citizen of the United States? Yes No

Please answer the following question for each insured that is a Non-U.S. Citizen:

Does the employee reside in the United States with a permanent resident visa? Yes No

If No, please provide visa information for all Non-U.S. Citizens.

Replacement:

Do you have any existing insurance policies or annuity contracts? Yes No

Will the policy being applied for result in any insurance or annuity contract in this or any other Company being lapsed, surrendered, reduced, subjected to substantial borrowing, or changed to paid-up, extended term or automatic premium loan? Yes No

If yes, details: _____

Company Name: _____

Policy Number: _____

Compliance Information:

The Securities Exchange Act of 1934 requires that we have reasonable grounds to believe, based upon the information provided by you, that your selections are suitable given your objectives and financial situation. Please complete the following relating to the suitability of your investment choices.

I have completed and returned the Confidential Prospective Corporate Purchaser Questionnaire, and I qualify either as an "Accredited Investor" as defined in Regulation D or as a "Qualified Purchaser" as defined in Section 3(C)(7) of the Investment Company Act of 1940, or both. Yes No

Do you understand that, under this policy, all payments and values including cash values and the death benefit are based on the investment experience of the Investment Divisions and are variable? Yes No

Do you believe that this policy will meet your objectives and anticipated financial needs? Yes No

I have received a copy of the current Private Placement Memorandum for this Flexible Premium Variable Universal Life Policy. Yes No

Agent Use Only:

- a. Purpose of Insurance _____
- b. Does the applicant have existing life insurance policies or annuity contracts? Yes No
- c. Do you have reason to believe the life insurance applied for will replace any insurance or annuity with us or any other company? Yes No

Agent's Declaration - I certify that I have asked and have fully recorded the proposed Insured's answers to all questions in this application. I know nothing that is material to the insurability of this life that has not been recorded herein.

Signature of Agent

Date

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent Share %: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent Share %: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent Share %: _____

This section must be completed for all simplified issue and fully underwritten cases.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART I

Name: _____ Occupation _____

Total life insurance in force: \$ _____ Driver's License # _____ State: _____

- 1. Have you applied for insurance in the past 6 months? Yes No
- 2. Have you ever been refused life insurance? Yes No
- 3. During the past 12 months have you used tobacco or nicotine products in any form? Yes No

During the past three years have you:

- 4. Flown as a private pilot or do you contemplate flying as a student pilot or crew member? (If yes, please complete the aviation questionnaire.) Yes No
- 5. Participated in or do you contemplate participating in any hazardous sport such as racing (automobile, snowmobile, motorcycle, boat), scuba diving, hang gliding, mountain or rock climbing? (If yes, please complete the hazardous sports questionnaire.) Yes No
- 6. **In the past three years**, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No
- 7. **In the past 10 years**, have you been medically advised that you have, or received any type of treatment for a positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

If you answered yes to questions 1-7, provide details: _____

This section must be completed for simplified issue only.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART II

Height: _____

Weight: _____

- 1. Do you have a personal physician? If yes, please provide name and address: Yes No
- 2. Please provide date last seen, reason seen and results: _____
- 3. Have any members of your immediate family died before age 60? Yes No
- 4. Are you currently taking any medication(s)? Yes No
- 5. Have you ever been hospitalized? (If yes, give details below including date(s) and reason(s)) Yes No

Within the past 10 years, has a member of the medical profession diagnosed you as having or treated you for any of the following:

- 6. Any permanent disease or disorder, including those requiring medical or surgical intervention of the heart, lungs, liver, kidneys, gastrointestinal system? Yes No
- 7. Elevated blood pressure, stroke, paralysis, or any chronic or progressive disease or disorder of the brain, spinal cord or central nervous system? Yes No
- 8. Blood disorders including chronic anemia? Yes No
- 9. Diabetes, cancer or malignancy? Yes No
- 10. Treatment for alcohol or drug use, or have you been medically advised to do so? Yes No
- 11. Any counseling or treatment for mental, nervous or emotional disorders? Yes No
- 12. Any physical impairments or diseases not listed above? Yes No

If you answered yes to questions 1-12, provide details: _____

This authorization must be completed for all simplified issue and fully underwritten cases.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The Company, its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for life insurance. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency, credit reporting agency or insurance company who possesses information of care, treatment or advice of me may furnish such information to the Company upon presenting this authorization or a photocopy. This authorization includes information about drugs, alcoholism and mental illness. The Company or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply. This authorization will be valid from the date signed for a period of two and one-half years. I have read this authorization and understand I have the right to receive a copy. I have received the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau. I consent to a consumer report containing personal or credit information or both that may be requested in connection with my application.

All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 1) No Information or answer to any question will be deemed communicated to or binding on the Company unless set out in this application. 2) Only the president, a vice president or the secretary of the Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Signed at _____ this ____ day of _____ year _____
City and State

Name of Proposed Insured (Please Print)

X _____
Signature of Proposed Insured

X _____
Witness

X _____
Signature of Owner

FRAUD WARNINGS

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts and Oregon: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**Notice of Insurance Information
Practices and Notice Regarding
Medical Information Bureau**

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your business associates, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Inquiries on the above notices should be addressed to:

[Great-West Life & Annuity Insurance
Company
Department 690, P.O. Box 1700
Denver, CO 80201]

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is:

[MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734
Phone: 866-692-6901 (TTY 866-346-3642)]

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS
REQUIRED OF ALL LIFE INSURANCE
PROVIDERS. BE ASSURED THAT
GREAT-WEST'S BUSINESS PRACTICES
MEET THE HIGHEST INDUSTRY
STANDARDS.

FIXED ACCOUNT OPTION ENDORSEMENT

THIS ENDORSEMENT IS ISSUED BY GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY AS PART OF THE POLICY TO WHICH IT IS ATTACHED. THE PROVISIONS OF THE POLICY APPLY TO THE ENDORSEMENT UNLESS OTHERWISE STATED HEREIN. ALL PROVISIONS OF THE CONTRACT THAT DO NOT CONFLICT WITH THE ENDORSEMENT APPLY TO THIS ENDORSEMENT.

FIXED ACCOUNT DESCRIPTION

The Fixed Account is a division of the Company's General Account that provides a fixed interest rate. This account is not part of and does not depend on the investment performance of the Variable Account.

The maximum allowed into the Fixed Account by any Owner may be limited by the Company.

PREMIUMS

Premiums will be allocated into the Fixed Account as directed by the Owner. The Company can prohibit additional premiums.

OWNERSHIP OF FIXED ACCOUNT

The Company has absolute ownership of the assets of the Fixed Account. Except as limited by law, the Company has sole control over the investment of the General Account Assets. The Owner does not share in the investment experience of the General Account, but is allowed to allocate and Policy Value Account into the Fixed Account.

POLICY VALUE ACCOUNT

The Policy Value Account is the Sub-Account Value plus the Fixed Account Value.

FIXED ACCOUNT VALUE

On any day, the Fixed Account Value is

- Premiums, less Expense Charges, allocated to the Fixed Account; plus
- Sub-Account Value transferred to the Fixed Account; plus
- Interest credited to the Fixed Account; minus

- The portion of any accrued policy fees and charges allocated to the Fixed Account; minus
- Partial withdrawals from the Fixed Account including any applicable partial withdrawal charges; minus
- Transfers from the Fixed Account, including any applicable Transfer charges.

During any policy month the Fixed Account Value will be calculated on a consistent basis. For purposes of crediting interest, policy value deducted, transferred or withdrawn from the Fixed Account is accounted for on a first in first out basis.

FIXED ACCOUNT INTEREST

The interest rate credited to the Policy Value Account in the Fixed Account is set by the Company but is guaranteed to be at least 2.5%. We may credit interest at rates higher than the minimum guaranteed rate. We will review the interest rate at least once a year, but at the Company's discretion. We may reset the interest rate monthly.

EFFECT OF A LOAN

When a policy loan is made, funds are transferred out of the Series Account or Fixed Account and into the Loan Account. When a policy loan is repaid, the amount of repayment is added according to current Premium allocations to the Series Account and Fixed Account.

A loan, whether or not repaid, will have a permanent effect on the Cash Surrender Value and on the Death Benefit, as described in this policy. If not repaid, any indebtedness will reduce the amount of

Death Benefit Proceeds and the amount available upon surrender of this policy.

A policy loan will not be treated as a taxable distribution under Section 72 unless:

- this policy is surrendered or lapsed while there is an outstanding loan; or
- this policy is a modified endowment contract.

If this policy is a modified endowment contract, a 10% penalty will apply to the amount of the loan included as gross income unless the loan is made after the date the Owner becomes 59½ or becomes disabled.

TRANSFERS

The Owner may make Transfers by Request, but no more frequently than every 60 days. The following provisions apply:

- (a) While this policy is in force, the Owner, by request may Transfer all or a portion of the Sub-Account Value among the Investment Divisions currently offered by the Company.
- (b) A Transfer will be effective upon the Transaction Date.

A Transfer out of the Fixed Account may only be made one time during a 365 day period and is limited to the greater of the maximum of 25% of the balance of the Fixed Account or the amount of the Transfer from the previous 365 day period.

A loan and a 1035 exchange will both be considered a Transfer.

Signed for Great-West Life & Annuity Insurance Company on the Issue Date of the policy (unless a different date is shown here)



[Mitchell T.G. Graye]
[President and Chief Executive Officer]

SERFF Tracking Number: GRWE-127174695 State: Arkansas
 Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 48818
 Company Tracking Number: PPVULSA-CSO
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
 Product Name: Flexible Premium Variable UL
 Project Name/Number: Flexible Premium Variable UL/Flexible Premium Variable UL

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR Compliance Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Attachment: PPVULappsar2.pdf		

	Item Status:	Status Date:
Satisfied - Item: Life & Annuity - Actuarial Memo		
Comments:		
Attachments: PPVUL Actuarial Memo 2011.pdf Fixed Account Actuarial Memo 2011.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter		
Comments:		
Attachment: AR letter.pdf		

	Item Status:	Status Date:
Satisfied - Item: Actuarial Memorandum		

SERFF Tracking Number: GRWE-127174695 State: Arkansas
Filing Company: Great-West Life & Annuity Insurance Company State Tracking Number: 48818
Company Tracking Number: PPVULSA-CSO
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: Flexible Premium Variable UL
Project Name/Number: Flexible Premium Variable UL/Flexible Premium Variable UL

Comments:

Attachments:

PPVUL Actuarial Memo 2011.pdf
Fixed Account Actuarial Memo 2011.pdf

**STATE OF ARKANSAS
INSURANCE DEPARTMENT**

CERTIFICATE OF COMPLIANCE

RE: Individual Flexible Premium Universal Life Policy page 12, Form PPVULrev
Individual Flexible Premium Universal Life Policy page 18, Form PPVULrev-CSO
Individual Flexible Premium Universal Life Application, Form PPVULappsar2

We hereby certify that the guidelines established in Arkansas Rule and Regulation 19 have been reviewed and the forms designated above comply with these guidelines.

We hereby certify that the above policy forms meet the minimum Flesch Reading Ease Test score requirements.

Great-West Life & Annuity Insurance Company



Susan Gile
Vice President, Individual Markets Operation

May 18, 2011

Date

Flexible Premium Variable Universal Life Insurance Application

Owner:

Name

Attention

Business Address

City State Zip Code

Owner's SS# or Tax ID #

Type of Business

Daytime Telephone Number

Evening Telephone Number

Insured:

Insured's Name

Date of Birth

Social Security #

Home Address

City State Zip Code

Business Address

City State Zip Code

Daytime Telephone Number

Evening Telephone Number

See attached Schedule of Insureds

Owner is: *(Please choose one of the following)*

- a. The Employer
- b. A Trust created by the Employer
- c. A Trust created by the Insured
- d. The Insured
- e. Other _____

Policy Information:

Life Insurance or Premium Applied for:

Total Face Amount: _____

Premium Amount: _____

Send Premium Notices to:

Name _____

Address _____

Death Benefit Option:

Please choose one of the following:

Option 1: Level Death Benefit

Option 2: Coverage Plus

Beneficiary(ies):

Please choose one of the following:

Employer Trust created by the Employer Trust created by the Insured

If the employer is the beneficiary, the employer certifies, represents and warrants that:

- a. The employer has a lawful and substantial economic interest in the life, health and safety of each proposed insured;
- b. The services of each such proposed insured are such that the employer expects to realize either:
 - A substantial monetary gain through the continued life of the proposed insured; or
 - A substantial monetary loss in the event of the proposed insured's death.
- c. Per the requirements set forth in I.R.C.§101(j), the insured:
 - had "compensation" in excess of the IRC § 414(q) limitation, as adjusted annually for inflation; or
 - is among the highest paid 35% of all employees, determined in accordance with the rules of IRC § 105(h); or
 - is an owner of 5% or more of the employer at any time during the year (or was in the preceding year); or
 - is among the top 5 highest paid officers of the company

Additionally, in order to comply with IRC§101(j), employers must obtain positive written consent from employees that the employer may insure their life. This consent must disclose that the corporation will reside as beneficiary of the policy death benefit and the maximum amount of insurance that may be issued on their life. This information must be obtained PRIOR to the issue of any policy. Failure to do so may result in adverse tax consequences.

Please sign below stating you have read and understand the above conditions.

Employer Name (Please Print)

Title

Employer Signature

Date

Citizenship Status:

Is each individual named on this application a citizen of the United States? Yes No

Please answer the following question for each insured that is a Non-U.S. Citizen:

Does the employee reside in the United States with a permanent resident visa? Yes No

If No, please provide visa information for all Non-U.S. Citizens.

Replacement:

Do you have any existing insurance policies or annuity contracts? Yes No

Will the policy being applied for result in any insurance or annuity contract in this or any other Company being lapsed, surrendered, reduced, subjected to substantial borrowing, or changed to paid-up, extended term or automatic premium loan? Yes No

If yes, details: _____

Company Name: _____

Policy Number: _____

Compliance Information:

The Securities Exchange Act of 1934 requires that we have reasonable grounds to believe, based upon the information provided by you, that your selections are suitable given your objectives and financial situation. Please complete the following relating to the suitability of your investment choices.

I have completed and returned the Confidential Prospective Corporate Purchaser Questionnaire, and I qualify either as an "Accredited Investor" as defined in Regulation D or as a "Qualified Purchaser" as defined in Section 3(C)(7) of the Investment Company Act of 1940, or both. Yes No

Do you understand that, under this policy, all payments and values including cash values and the death benefit are based on the investment experience of the Investment Divisions and are variable? Yes No

Do you believe that this policy will meet your objectives and anticipated financial needs? Yes No

I have received a copy of the current Private Placement Memorandum for this Flexible Premium Variable Universal Life Policy. Yes No

Agent Use Only:

- a. Purpose of Insurance _____
- b. Does the applicant have existing life insurance policies or annuity contracts? Yes No
- c. Do you have reason to believe the life insurance applied for will replace any insurance or annuity with us or any other company? Yes No

Agent's Declaration - I certify that I have asked and have fully recorded the proposed Insured's answers to all questions in this application. I know nothing that is material to the insurability of this life that has not been recorded herein.

Signature of Agent

Date

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent Share %: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent Share %: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Name: _____
Agent Number: _____
Agent Signature: _____
Agency/Institution: _____
Office: _____
Address: _____

Agent Share %: _____

Agent Share %: _____

This section must be completed for all simplified issue and fully underwritten cases.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART I

Name: _____ Occupation _____

Total life insurance in force: \$ _____ Driver's License # _____ State: _____

- 1. Have you applied for insurance in the past 6 months? Yes No
- 2. Have you ever been refused life insurance? Yes No
- 3. During the past 12 months have you used tobacco or nicotine products in any form? Yes No

During the past three years have you:

- 4. Flown as a private pilot or do you contemplate flying as a student pilot or crew member? (If yes, please complete the aviation questionnaire.) Yes No
- 5. Participated in or do you contemplate participating in any hazardous sport such as racing (automobile, snowmobile, motorcycle, boat), scuba diving, hang gliding, mountain or rock climbing? (If yes, please complete the hazardous sports questionnaire.) Yes No
- 6. **In the past three years**, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? Yes No
- 7. **In the past 10 years**, have you been medically advised that you have, or received any type of treatment for a positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

If you answered yes to questions 1-7, provide details: _____

This section must be completed for simplified issue only.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART II

Height: _____

Weight: _____

- 1. Do you have a personal physician? If yes, please provide name and address: Yes No
- 2. Please provide date last seen, reason seen and results: _____
- 3. Have any members of your immediate family died before age 60? Yes No
- 4. Are you currently taking any medication(s)? Yes No
- 5. Have you ever been hospitalized? (If yes, give details below including date(s) and reason(s)) Yes No

Within the past 10 years, has a member of the medical profession diagnosed you as having or treated you for any of the following:

- 6. Any permanent disease or disorder, including those requiring medical or surgical intervention of the heart, lungs, liver, kidneys, gastrointestinal system? Yes No
- 7. Elevated blood pressure, stroke, paralysis, or any chronic or progressive disease or disorder of the brain, spinal cord or central nervous system? Yes No
- 8. Blood disorders including chronic anemia? Yes No
- 9. Diabetes, cancer or malignancy? Yes No
- 10. Treatment for alcohol or drug use, or have you been medically advised to do so? Yes No
- 11. Any counseling or treatment for mental, nervous or emotional disorders? Yes No
- 12. Any physical impairments or diseases not listed above? Yes No

If you answered yes to questions 1-12, provide details: _____

This authorization must be completed for all simplified issue and fully underwritten cases.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The Company, its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for life insurance. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency, credit reporting agency or insurance company who possesses information of care, treatment or advice of me may furnish such information to the Company upon presenting this authorization or a photocopy. This authorization includes information about drugs, alcoholism and mental illness. The Company or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply. This authorization will be valid from the date signed for a period of two and one-half years. I have read this authorization and understand I have the right to receive a copy. I have received the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau. I consent to a consumer report containing personal or credit information or both that may be requested in connection with my application.

All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 1) No Information or answer to any question will be deemed communicated to or binding on the Company unless set out in this application. 2) Only the president, a vice president or the secretary of the Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Signed at _____ this ____ day of _____ year _____
City and State

Name of Proposed Insured (Please Print)

X _____
Signature of Proposed Insured

X _____
Witness

X _____
Signature of Owner

FRAUD WARNINGS

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts and Oregon: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**Notice of Insurance Information
Practices and Notice Regarding
Medical Information Bureau**

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your business associates, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Inquiries on the above notices should be addressed to:

[Great-West Life & Annuity Insurance
Company
Department 690, P.O. Box 1700
Denver, CO 80201]

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Recording Act. The address of the Bureau's information office is:

[MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734
Phone: 866-692-6901 (TTY 866-346-3642)]

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS
REQUIRED OF ALL LIFE INSURANCE
PROVIDERS. BE ASSURED THAT
GREAT-WEST'S BUSINESS PRACTICES
MEET THE HIGHEST INDUSTRY
STANDARDS.



8515 East Orchard Road
Greenwood Village, CO 80111 Tel. (303) 737-3000
Address mail to: P.O. Box 1700, Denver, CO 80201
www.gwla.com

May 18, 2011

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

NAIC #769-68322

RE: Individual Life Submission

Individual Flexible Premium Universal Life Policy,
Deletion of Page 1, Form PPVUL-CSO SF (Death Benefit Option 3)
Revised page 12, Form PPVULrev
Revised page 18, Form PPVULrev-CSO
Individual Flexible Premium Universal Life Application, Form PPVULappsar2
Fixed Account Endorsement, J379r2

Enclosed for your review and approval are the above referenced forms. The policy pages and application are being updated to remove the third death benefit option from the previously approved filing. The third Death Benefit (Option 3) is being removed because the targeted Market has proved not to exist, in fact this option has never been chosen at any time since this product has been offered.

Form PPVULsa-CSO was previously approved under SERFF Tracking No. GRWE-125682152 on June 9, 2008. PPVULappsar-r1 was approved under SERFF Tracking GRWE-126158024 on May 22, 2009.

We are filing a revised actuarial memorandum as well with no other changes other than the removal of the third death benefit option.

We are also filing for approval the Fixed Account Endorsement that is offered with this policy. This endorsement expands the investment options in the policy and allows the policy owner to direct premiums into a fixed account. This endorsement, Form J379r, was previously approved under SERFF Tracking No. GRWE-126312295 on September 22, 2009. The only difference between this endorsement and the previously approved endorsement is the guaranteed interest rate.

The amended pages and endorsement will be used for new issues only. ***We certify no other changes are being made to these previously approved forms.***

The forms submitted are:

- are in final printed form;
- are being submitted in all states where we are licensed;
- are exempt from Flesch Readability requirements because this product is registered with the Securities & Exchange Commission; and
- are exempt from filing in Colorado, our state of domicile, pursuant to Regulation 5-92. Colorado requires a fee to be paid each February 28th based on our Company's direct written premium. If appropriate, a retaliatory fee has been paid in your state in conjunction with your annual premium tax return.

We reserve the right at any time to make non-material changes to this form, including (but not limited to) paper stock, type face (but not font size) and page layout made necessary by unavoidable changes.

To the best of our knowledge, this submission complies with your state laws and regulations. We look forward to your approval. If you have any questions or concerns, please feel free to contact me.

Sincerely,

A handwritten signature in black ink that reads "Tanya D. Gonzales". The signature is written in a cursive style with a large, stylized initial 'T'.

Tanya D. Gonzales
Manager, Individual Markets
(FAX) 303-737-5829
(PHONE) 800-537-2033, extension 75829
E-MAIL: Tanya.gonzales@gwl.com